After an exposition of local antiphlogistic measures, such as heat, hot milk and carbolized water injections, silver nitrate placed in the cervical canal, alum insufflations and other astringent washes of an almost inquisitorial nature, he concludes hopefully and benignly, "inflammatory ulceration of the cervix uteri, not being, *per se,* a fatal disease."

These men antedated by some decades the modern throes of gynecological rebirth, yet their case records demonstrate a pleasing number of probable cures, and a large number of relieved patients, for whom life was made more endurable; and more pleasing still, they were the recipients of vastly more gratitude and appreciative recognition than obtains in this age of hypersophistication.

THE MODERN PERIOD

Now the flickering torch of revivified knowledge in the modern phases of gynecology began to gleam. Lawson Tait, Sims, McDowell, and illustrious others, all infused increased energy into the shedding of light, and then Howard Kelly, in this country, gave it its greatest encouragement, impetus, and brilliance.

It is interesting and thought-provoking to observe that from even the earliest times down to our own, there appear to be cyclical swingings to and fro, hand in hand with all the succeeding advances in medical, chemical and biological science; now to that side which advocates the complete destruction and extirpation of tissue and its contained noxa, regardless of fact or function, then to the side of the chemical disinfectants directed chiefly against the bacterium itself. Then, ever and anon, "the still small voice" gains volume through the incisive, reverberations of surgical and semi-surgical argument, pleading, "Hold! why not give the tissues themselves a chance? Surely, Mother Nature, if relieved of some overburden and her intrinsic reparative ability abetted, can carry on." For a while the more moderate methods tending to increase local tissue resistance, rather than mutilative ablations, prevail; then, behold, some new, supposedly powerful germicide is "hozzanaed" forth under the all-puissant trade-mark of some grandiose pharmaceutical house, garnished in the flamboyant banners and gaudy clamant fustian of intemperate advertising; poor critique, combined with exaggerated claims of what it can do *in vitro,* presented in pseudoscientific reports, and the whole "devil's dance" whirls on again until the next generation, perhaps, fortified and informed by experimentation, tragic failures and numerous reliable clinical reports decides again for "common sense."

IN CONCLUSION

An historical and philosophical purview of this subject, similar to that of any other of life's activities, is always intriguing and enlightening. In the illumination of our present attitude, modern *modi operandi,* and following intimately the dictum of Huxley, "that science is organized common sense," leavened with knowledge, it is noteworthy and arresting that the same "natural" methods that we use today—heat, hyperemia, astringent applications, posture, hygiene, packs, pessaries, etc., were in use in the dim vistas of the Babylonian desert and on the uptilted escarpments of the Oxus River when civilization was germinating; and that when these men, too, used extreme measures their practice, in keeping with their more heroic age, was, perhaps, more drastic in degree but differing not at all in kind from ours.

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CLINICAL NOTES AND CASE REPORTS

BREAST SUPPORT

By HARRY S. FIST, M.D.
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AN ideal breast binder would hold the breasts in the position which is normal in lower animals. In prehistoric days, when the human race walked on all-fours, breast binders were not needed. Now, because of the upright posture, the breasts drop against the chest, so that milk flow and lymph drainage are interrupted.

For years physicians have recognized the necessity for a breast support, especially during the period after childbirth, when breasts are engorged and painful, and secretion of milk begins.

The first breast binders were merely strips of cloth pinned around the chest, pressing on the breasts, interfering with axillary lymph drainage. Later, binders were shaped to the body more or less, but the first really satisfactory breast support was described in 1919 by Dr. Alfred C. Beck.[1] This binder originally consisted of a piece of old sheet about eighteen inches wide and fifty-four inches long. The middle portion covered the patient's back, and each end was brought across the breast of one side and over the opposite shoulder, where it was pinned to the top of the back portion of the cloth. A towel was used as a pad. The flaps were pinned together in front at top and bottom. This binder lifted the breasts

1 *Medical Times,* 1919.

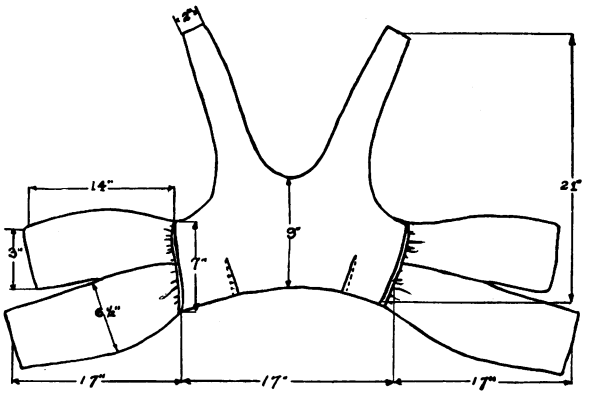

Fig. 1.—The binder with dimensions.

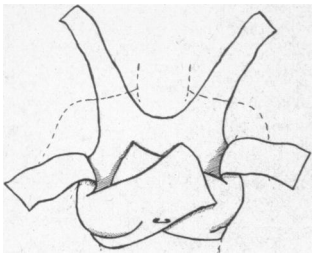

Fig. 2

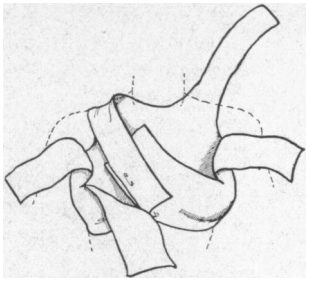

Fig. 3

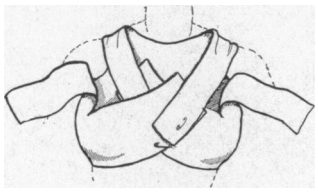

Fig. 4

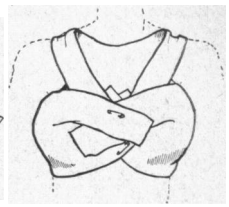

Fig. 5

Fig. 2.—Anchored by pin at bottom.

Fig. 3.—One shoulder strap pinned to lower margin of opposite lower flap.

Fig. 4.—Second shoulder strap pinned to lower margin of opposite lower flap.

Fig. 5.—Upper flaps folded across and held with one pin through all thicknesses.

without undue pressure, but was bulky and uncomfortable in the back, especially at the spots where it was pinned.

Later, Doctor Beck improved this binder by dividing each end of the cloth into a longer lower flap and a shorter upper flap. By bringing the lower flaps up and pinning over the opposite shoulder, a support was formed which assumed the natural form of the breasts, holding them up without pressing them against the chest.

The author's binder utilizes the principles described by Beck, but adds the following changes: the back is shaped, and has long shoulder straps which permit pinning in the front so the patient may herself easily apply the binder. Bunching is avoided, and there are no lumps or safety pins in the back.

This binder, as illustrated (Fig. 1), has proved satisfactory in the maternity department of the Cedars of Lebanon Hospital for over three years, and is now in use in the Los Angeles General Hospital. It is satisfactory only when correctly applied. The author's method is as follows:

1. Place the binder around the body, with the large flat surface in back, and pin the lower flaps snugly together at the bottom to anchor the binder. (Fig. 2.)

2. Pin the lower edge of one lower flap to the shoulder strap of the opposite side, thus lifting one breast. (Fig. 3.)

3. Pin the lower edge of the other lower flap to the second shoulder strap, lifting the second breast. (Fig. 4.)

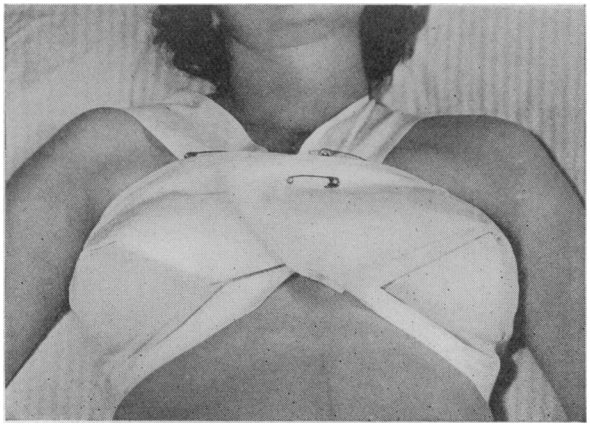

Fig. 6.—Photograph of binder as applied.

4. Fold both upper flaps across the upper portions of the breasts and pin in the middle through all layers of cloth. (Figs. 5 and 6.)

5. For nursing, simply unpin the upper flaps and that lower flap which supports the breast to be nursed. These two pins are easily replaced by the patient.

SUMMARY

This easily made binder, of unbleached muslin, is inexpensive, washable, adjustable, and comfortable, furnishing excellent breast support. It is especially useful for puerperal patients.*

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LIVER SUPPURATION

A SUMMARY: WITH CONCLUSIONS

By JOHN W. SHUMAN, M.D.
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WHEN we see in a medical journal a lengthy article upon a subject that interests us, we turn to the end of it, and if there is a summary and a conclusion we read them; if not, we are apt to turn on. So herewith a summary:

SUMMARY

1. *Solitary Abscess.*

The single liver abscess is amebic in origin, and comes from the large intestine through the portal vein.

If we have a patient with a fever of unknown origin, who chills and sweats, has liver pains, dyspepsia and a loss of weight, amebic liver abscess should be thought of until we can prove otherwise. Looking through the fluoroscope in such a patient will show the right diaphragm higher and less movable than the left, if an abscess is present in the upper portion of the right lobe. The blood will show a leukocytosis in most instances. If, with the aid of a trocar, we can secure amebic pus, the diagnosis is made.

Surgical drainage should be instituted. Adequate emetin hydrochlorid in quantity sufficient is excellent medicine for amebic patients.

A large abscess causes the patient to lie on the right side or to insist upon being propped up; liver dullness is increased; there is rigidity of the upper right belly wall; and if the abscess is

* Credit is due Miss Minnie Eichenberger for valuable assistance in designing this binder.